Section 111 Mandatory Insurer Reporting and Hospital Claims Management
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Mandatory Medicare Reporting

- Section 111 of the Medicare, Medicaid and SCHIP Extension Act creates mandatory reporting obligations for payers that apply to payments to or settlements with Medicare beneficiaries.
- Changes how Medicare gathers information regarding who is or who may be responsible to pay for a Medicare beneficiary’s care.
- Statutory penalty for failure to submit a required report may be subject to a fine of $1,000 per day per claimant.

Secondary Payer Actions

- Section 111 does not change or modify any existing laws or obligations under Medicare Secondary Payer Act.
- However, Medicare has become more aggressive in asserting secondary payer rights and has begun targeting third party payers for reimbursement.
- The new reporting requirements will assist Medicare in identifying and pursuing reimbursement claims and claims on which Medicare may deny coverage.
**Basic Requirement**

- Responsible Reporting Entities (RREs) are required to report:
  - Any settlement, judgment, award, or other payment to a Medicare beneficiary, when medical expenses are claimed or released.

- There are two categories of reportable claims:
  - One-time payments (TPOC - “Total Payment Obligation to Claimant”).

**Scope of Reporting Requirements**

- Generally applies to any payer on a claim – Responsible Reporting Entities (RREs) include liability insurers, workers’ compensation insurers, no-fault insurers, and self-insureds. Self-insured is defined very broadly, encompassing all risk scenarios which are not covered by third-party insurance.

- Reporting is limited to claims involving Medicare beneficiaries.
  - Over 65.
  - Social Security Disability for 24 months.
  - End-stage renal disease or ALS patients.

- Neither a release nor an admission of liability is required to trigger reporting obligation.

**Electronic Information Exchange**

- All reporting information is submitted electronically, through secure data exchange process.
  - Web-based Direct Data Entry available for RREs with limited reports.

- Reporting done on a quarterly basis.
  - CMS now permits off-cycle reporting, on limited basis (e.g., for termination of ORM).
**Reporting Trigger Dates**

- Promises to pay for or provide future care (ORMs) have been subject to reporting requirements since 2010.
- The initial mandatory reporting period for traditional settlements in liability cases (TPOCs) was the first quarter of 2012 and applied to settlements reached after October 1, 2011.

**TPOC Reporting Thresholds**

<table>
<thead>
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<th>TPOC Threshold</th>
<th>TPOC Date</th>
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<tbody>
<tr>
<td>$100,000</td>
<td>10/1/11 – 3/31/12</td>
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<tr>
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<td>4/1/12 – 6/30/12</td>
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<td>$5,000</td>
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<tr>
<td>$300</td>
<td>10/1/14 –</td>
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In 2014, threshold are going to be adjusted and may not have the threshold of $2,000 and then, $300.00.

**Risk Management Write Offs**

- CMS has stated that health care risk management write-offs of charges for past care are not reportable.
  - **Rationale:** Medicare is made aware of such write-offs through the normal Medicare billing process, which requires such write-offs to be identified as third-party insurance payments. As such, write-offs may still result in Medicare considering the health care provider to be the primary payer and implicate secondary payer concerns.
- Gift cards, etc. are not considered write-offs and are treated as reportable TPOCs, subject to applicable thresholds.
- A promise to write-off charges for future care is treated as a reportable ORM.
ORM Reporting

- No dollar threshold applicable to ORM reporting.
- Obligation to monitor Medicare beneficiary status of ORM recipients who were not Medicare beneficiaries at time of promise/acceptance of responsibility.
- RRE must update report if ORM terminates.
  - Death of the beneficiary.
  - Settlement that releases ongoing responsibility.
  - Specific terms of the original acceptance of responsibility.
  - Signed statement from treater that no further treatment will be required.
- RRE need not wait until next quarterly report window to report ORM termination.

How Do I Know If a Claimant Is a Medicare Beneficiary?

- Reporting limited to Medicare beneficiaries.
- Electronic query system available through CMS to determine Medicare status.
- Limited online web-based query function also available.

Query Information

- Required Information
  - Name (first and last)
  - SSN or HICN
  - Date of birth
  - Gender
- Should have information by time of settlement, if not sooner.
- CMS has issued model language/form for situations in which a claimant refuses to divulge SSN (available through Section 111 website).
Reporting Extends to All Medicare Beneficiaries Who Sign a General Release

- Reporting extends to all Medicare beneficiaries who have claimed medicals or who are releasing any claim for medicals.
- Therefore, reporting extends to any Medicare beneficiaries, in addition to the patient, who may be parties to a general release of all claims (spouses, children, etc.).

Report Includes ICD-9 Codes Relating to All Alleged Injuries

- A TPOC report includes all injuries alleged by the settling plaintiff to have been caused by the defendant/payer.
  - ICD-9 Diagnosis Codes are submitted.
- Codes will define what injuries or conditions Medicare considers to be related to the claim.

Report Includes Total Amount of Payment

- Report includes the total amount of the payment or value provided to the claimant.
  - Cumulative total, if multiple payments are made, including all different categories of payments made to or on behalf of a Medicare beneficiary.
  - The total amount paid by the RRE is to be reported, not the amount allocated by the parties to medical expenses or to a particular claimant.
  - For annuities, the amount reported is the greater of the projected payout or the guaranteed payout, not the cost of the annuity.
**Reporting of Wrongful Death Claim**

- A claim asserting the wrongful death of a Medicare beneficiary must be reported, notwithstanding the fact that, in many states, a wrongful death claim is generally limited to the damages suffered by the survivors and does not include any recovery for medicals.
- State law may be a defense to a lien or secondary payer claim, but does not eliminate reporting obligation.
- All statutory beneficiaries are reported in separate fields, designated as “Claimants.”

**Settlement Issues and Considerations**

- Federal law creates an affirmative obligation to consider and protect Medicare’s interests in the context of liability settlements.
  - Obligation relates both to the claimant’s past medical expenses paid by Medicare and the claimant’s future medical needs.
- Lien issues should be addressed and analyzed early in the process.
  - Information regarding conditional payment amounts must be gathered prior to mediation.

**Settlement Documentation**

- In order to protect payers against potential Medicare or other reimbursement or lien claims, settlement agreements may contain a number of specific provisions addressing Medicare secondary payer and reporting issues.
- In appropriate cases, the release document may include some or all of the following:
**Claimant Responsible for Liens**

- A provision that the claimant(s) will accept, and be responsible for, all liens and reimbursement claims, including Medicare claims.

**Indemnity**

- An indemnity obligation flowing from the claimant(s) to the released parties in the event a lien or reimbursement claim is asserted against any released party related to the claim.

**Separate Escrow/Trust Account**

- An escrow/trust account to be set up by the claimant’s counsel with specified funds from the settlement payment in an amount equal to or greater than Medicare’s conditional payments and/or other lien amounts.
  - Funds to be used solely to pay off any existing liens or conditional payment claims, with any remaining escrowed funds to be released to the claimant(s) upon provision of proof that the lien or claim has been satisfied or released.
- Alternative: Use of multi-party checks, with Medicare or other lien holder listed as additional payee.
Language Reflecting Consideration of Medicare’s Interests

- Language in the settlement agreement reflecting the parties’ consideration of Medicare’s interests and acknowledgments by the claimant(s) as to matters relating to Medicare benefits and the possible impact of the settlement on such benefits.

Medicare Consideration Provisions

- Avowal that parties do not intend to pass on to Medicare financial responsibility for injuries intended to be compensated under agreement.
- Agreement that any rights of recovery will be satisfied by Releasors.
- Acknowledgment by Releasors and counsel that Medicare may seek reimbursement from settlement proceeds and/or deny future coverage.
- Agreement by Releasors to reimburse Medicare for any conditional payments in timely manner.
- No representations or warranties as to impact on future Medicare benefits.

Medicare Consideration Provisions (cont’d)

- Acknowledgment that Releasors have sought advice of counsel as to Medicare issues.
- Releasors agree to cooperate with Releasors with respect to all reporting obligations and with respect to any third-party claim for reimbursement.
- Acknowledgment that settlement will be reported and release of any claim arising out of reporting.
- If Medicare Set Aside (“MSA”) is part of settlement:
  Releasors are responsible for all obligations relating to self-administration of MSA.
  Releasors are not responsible for administration of MSA or for selecting any third party as administrator.
  Release of all claims against Releasors arising out of administration of MSA.
**Creation of a Medicare Set-Aside**

- Release may include a Medicare Set-Aside, to address and cover the claimant’s future medical needs.
- An MSA is a form of a trust, usually self-administered by the claimant and subject to certain Medicare rules, in which an amount of money taken from the proceeds of a settlement is set aside to be used solely to pay for Medicare-covered future care.

**MSAs**

- No current federal statute or regulation specifically mandates the use of MSAs in liability cases.
- However, an MSA is a tool that reflects consideration of Medicare’s interests when future care that would otherwise be covered by Medicare is part of a claim and part of what is covered by the settlement agreement/release.

**MSA Review**

- Medicare is under no legal obligation to review MSAs in liability cases.
- In liability context, parties may elect not to submit MSAs to CMS for approval.
The MSA Process

- MSAs are created by independent and certified Medicare specialists who review the claimant’s medical records.
- The MSA specialist analyzes and determines the necessary treatment and medical goods and prescriptions that would otherwise be covered by Medicare and prices such items, based upon the rated age/life expectancy of the claimant.

Possible Triggers for a Medicare Set-Aside

- An MSA may be considered in liability matters involving substantial claims in which future care that would otherwise be covered by Medicare has been alleged, is likely to occur, and is being released.
  - Is claimant a Medicare beneficiary?
  - Has claimant applied for SSDI/appealing a denial of SSDI?
  - Has the claimant alleged permanent or ongoing disability/injuries?
  - Has claimant alleged (or have claimant’s treaters indicated) that substantial future care is required?

MSA Funding

- MSAs can be funded by a lump sum or by an annuity.
  - Annuity can reduce the cost of the MSA and/or help assure that the monies are not exhausted prematurely.
**Settlement and Claims Management Implications**

- Timing of mediation may delay settlement.
- Issues may be unfamiliar to plaintiffs’ counsel and settlement provisions may be unpopular.
  - Consider pre-mediation meeting(s) with counsel.
  - Provide MSA in advance of mediation.
  - Third-party vendors may offer MSA and secondary payer assistance.
- Problems may arise in multi-party “first to settle” cases and in cases where disputed liability or causation issues may reduce settlement value below expected cost of future care.
- Emphasize to plaintiffs’ attorneys that secondary payer issues and reimbursement claims are not solely the payer’s concern and that suggested Medicare provisions serve to protect plaintiffs and plaintiffs’ counsel as well.

**Recent Changes to Recovery Process**

- Medicare Secondary Payer Recovery Portal
  - Available to beneficiaries, attorneys, insurers, TPAs.
  - Allows online access to review and update certain case specific information.
    - Submit proof of representation or consent to release documentation.
    - Request conditional payment information.
    - Dispute expenses designated as conditional payments.
    - Submit case settlement information.
  - Requires registration through: [https://www.cob.cms.hhs.gov/MSPRP/](https://www.cob.cms.hhs.gov/MSPRP/)

**Additional Changes and Options**

- Self-Calculation of Final Conditional Payment Amount, for settlements less than $25,000.
- Fixed percentage option, for settlements less than $5,000.
- Generally, no conditional payment claim on settlements of $300 or less.
- Recent “Advanced Notice of Proposed Rulemaking.” Beginning of process of creating federal regulations governing protection of Medicare’s interests with respect to future medicals in liability cases.
**Scenario #1**

- In August 2012, a patient submits a demand to a Hospital’s Risk Management Department alleging injuries relating to an IV infiltration which occurred in July 2012. On September 28, 2012, Risk Management and the patient verbally agree to settle the claim for $7,500. A settlement agreement and release is prepared and becomes fully executed on October 9, 2012.

**Answer**

- Is the patient a Medicare beneficiary?
- The relevant date is October 9, 2012 (the date the agreement becomes final, binding and enforceable).
- If the patient is a Medicare beneficiary as of October 9, 2012, the settlement is reportable as a TPOC.
  - TPOC reporting threshold is $5,000 as of October 1, 2012.

**Scenario #2**

- A medical clinic visitor and Medicare beneficiary falls and injures her foot, in June 2012. The visitor is examined and x-rayed, and a fractured heel is diagnosed. The cost of the examination and x-ray is written off, and the visitor is told by the clinic staff at the time of her discharge that the clinic will cover any and all future expenses associated with the fractured heel. The patient leaves the clinic without receiving any further care, and nothing further is heard from the visitor.
**Answer**

- The claim is reportable as an ORM. The health care provider assumed responsibility to cover the beneficiary’s future care relating to the fractured heel.
- The reporting of an ORM is based on the promise made and does not require any actual payments to be incurred in order to trigger the reporting obligation.
- No termination of the ORM can be reported, since the promise was open-ended and has not been exhausted.
- If the patient was not a Medicare beneficiary, there would be no report, but there would be an obligation to monitor the visitor’s Medicare status throughout the life of the promise and to report if the visitor became a beneficiary while the promise was still open.
- The write-off of the examination and x-ray is not separately reported.

**Scenario #3**

- In December 2010, a Medicare beneficiary with a pressure ulcer was told by the Hospital that the Hospital would cover all future medical costs associated with that pressure ulcer. While the patient continued to treat for the pressure ulcer (and the Hospital continued to write-off and/or pay for the associated expenses), negotiations were ongoing. On October 15, 2011, a settlement was reached, under which the patient received a lump sum of $500,000, in exchange for a complete release.

**Answer**

- The claim is reportable, **both as a TPOC and as an ORM**.
- The TPOC report consists of the $500,000 lump sum settlement payment.
  - The write-offs and payments for ongoing care are not included in the TPOC report, because they were made pursuant to the ORM, which is reported separately.
- If the injured person’s spouse also signed the general release, there may be an obligation to separately report as to the spouse as well, if the spouse is a Medicare beneficiary.
  - In that circumstance, the BRE is not permitted to apportion the payment as between the spouses for reporting purposes, and each report would include the entire $500,000.
Questions?

Follow Up:

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